MONTANA
Department of Public Health & Human Services

xerox

Montana Health Care Programs
Claim Inquiry Form

Provider Name _____
Contact Person _____
Address _____
Date _____
Phone Number _____
Fax Number _____

Mail to:
Provider Relations
Xerox State Healthcare, LLC
P.O. Box 8000
Helena, MT 59604

Fax to:
(406) 442-4402

For status on a claim, please complete the information on the **left side** of this form and mail to the address above or fax to the number shown. You may include a copy of the claim, but it is not required.

NPI/API _____
Client Number _____
Date of Service _____
Total Billed Amount _____
Date Submitted for Processing

Xerox Response _____

NPI/API _____
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